HOSPITAL CASE MANAGEMENT

THE ESSENTIAL GUIDE TO HOSPITAL-BASED CARE PLANNING

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INSIDE

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To Get it Right Up Front, You Have to Be Up Front

ED case managers are essential in today's world

"Get everything right up front," is the mantra hospital case managers have been hearing for years. But the only way case managers can ensure that things are right "up front" is to see patients up front, as they are admitted to the hospital.

Since the vast majority of non-elective patients come in through the emergency department (ED), stationing case managers in the ED is a necessity in today's healthcare environment.

"The emergency department

EXECUTIVE SUMMARY

Emergency department case managers are essential to prevent payer denials by ensuring that patient status and level of care is correct; prevent admissions and readmissions by linking patients to community services; improve patient throughput by ensuring that tests are procedures are conducted in a timely manner; and to facilitate hospice and palliative care referrals.

- Case managers should cover the ED seven days a week during the hours when the volume is highest. Hospitals with a lot of payers that require preauthorization, or a large volume of complex patients, or those with behavioral disorders may need 24-hour coverage.
- EDs also need social workers on hand to coordinate community services, facilitate mental health referrals, and handle issues such as abuse, neglect, domestic violence, and chemical dependence.
- The best candidates for ED case management positions are experienced case managers with a high level of clinical knowledge, good organizational skills, and the ability to work quickly.

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care management team can have a profound impact on their organization's operations by preventing admissions when patients could be cared for in another setting, improving patient throughput, enhancing patient safety, and increasing patient satisfaction. The role of the emergency department case manager is extremely critical to managing the delivery of care and the next level of care for the patient," says **Patricia Hines**, PhD, RN, managing director and care management transformation practice lead with Novia Strategies, a national healthcare consulting firm.

One of the most important reasons for having case managers and social workers in the ED is to determine if patients meet inpatient criteria and to ensure they get to the right level of care. They provide value to the hospitals as well as to patients and families in many other ways, adds **Karen Zander**, RN, MS, CMAC, FAAN, president and chief executive officer for The Center for Case Management. *(For a look at some of the tasks that ED case managers should perform, see related article on page 92.)*

Case managers in the ED basically have the same role as their counterparts on the floor — they just need to do the work quickly, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

"Emergency department case managers have the responsibility for utilization management, level of care, discharge planning, and facilitating treatments and procedures in a timely manner," she adds.

ED case managers should focus on patients who have been discharged within 30 days to determine why the patient is coming back and if a readmission can be avoided, Cesta suggests.

Another priority should be patients who don't have an actual diagnosis, such as patients who complain of abdominal pain or headache. "These are not diagnoses; these are signs and symptoms. Soft diagnoses are what the Recovery Auditors jump on. If the patient record lists only the signs and symptoms, the case managers should ask the physician to list the presumptive diagnosis," Cesta says.

After the potential readmissions and soft diagnoses, the next priorities for ED case managers is to assess patients who are likely to be admitted, saving time for the case managers on the unit and working with high-utilizing patients to help them access a primary care provider and avoid another visit, Cesta says.

Cesta tells of a patient who came back to the ED complaining of chest pain four times in a short period of time. The case manager in the ED looked at the patient's lab work and saw that he appeared to be anemic. She got the patient an appointment the next day with a primary care physician who treated the anemia, which, in turn, prevented more ED visits by the patient.

"This is a great example of how emergency department case managers can link the patient with services in the community and avoid a hospital admission. Knowing that the patient had a physician appointment the next day helped the emergency department case managers feel comfortable in discharging the patient. The primary care intervention also prevented more emergency department visits," she says.

These days, patients who come through the ED tend to be sicker than in the past because many patients with minor complaints and those who can afford to pay go to urgent care facilities if they have medical issues when their physician office is closed,

Zander points out.

"Somebody needs to be in the emergency department to coordinate care and discharge services for patients who present with multiple comorbidities and/or psychosocial issues, and that's where case managers and social workers can be a big asset," she says.

Hospitals need two disciplines — RN case managers and social workers — in the ED at peak times to cover all the tasks that arise, Zander says. They should be dedicated specifically to the ED and not called down from other places unless it's a critical access hospital with limited staff, she adds.

Nurses, not social workers, have the expertise to make suggestions on patient status to the admitting physician. Social workers are essential when patients, especially those with behavioral health issues, need other services in the community in order to be safely discharged, Zander points out.

Case managers and social workers should collaborate to ensure that patients get the services they need in the right setting, adds **Nancy Magee**, BSN, MSN, RN, senior consultant for Novia Strategies.

"Social workers have expertise on community resources such as knowing which homeless shelter has a nurse on staff or which patients qualify for medication assistance. In some cases, they can help patients avoid an admission by setting them up with home health or durable medical equipment, or other community services," she adds.

Social workers also can provide valuable help for the clinical staff in the ED by addressing issues such as abuse, neglect, domestic violence, and chemical dependency; setting up referrals for patients with psychiatric issues; and educating patients and family members about end-of-life options, Magee says.

Hospitals should staff the ED seven days a week but not necessarily 24 hours a day, Zander says. Instead, she recommends staffing the ED with a case manager and a social worker during the times when the volume is highest. Saturday, Sunday, and Monday are usually the ED's busiest days, she adds.

"Having care managers work a standard 9 a.m. to 5 p.m. shift Monday through Friday is not effective because that's not usually when emergency departments have the highest volume," Magee adds.

Zander advises case management departments to collect data on patient volume and busy times of day and days of the week, and then work with the hospital administration to determine when case managers are really needed.

The number of ED case managers and the hours they work will vary depending on each hospital's patient population, Cesta says. One rule of thumb to keep in mind is that, on average, case managers can touch about 20 patients in an eight-hour shift in the ED, she says.

Staffing patterns can vary by payer mix and case mix index, Magee adds.

For instance, hospitals with a significant number of payers that require preauthorization for any services may need to staff the emergency department 24/7, she says. Round-the-clock staffing also may be a good idea when a majority of patients have multiple comorbidities, behavioral health issues, or both, Magee adds.

"When the emergency department gets busy, the clinical team will be pressed for time and may have difficulty making the preauthorization telephone calls," Magee says. "Alternatively, they may treat the immediate problem and not deal with other issues."

When assigning staff to the ED, case management directors should consider that many EDs are often busiest during off hours and weekends when physician offices and clinics are closed, Hines says. "Hospitals may need more case managers and social workers on the weekends to help with throughput in the emergency department," she says.

Magee cites guidelines that suggest one FTE case manager for every 20,000 to 30,000 ED visits each year, but adds that there are other factors that influence hospitals' needs.

"Some large medical centers that have a high volume of patients with behavioral health issues need to have two or three case managers in the emergency department during peak times and staff the emergency department 24/7," Hines says. Hospitals that have a high volume of behavioral health and substance use disorder patients may find it beneficial to have a separate psychiatric ED, often called a "Crisis Center," Zander adds.

Smaller hospitals should analyze patients' arrival times and assign a case manager to the ED at the busiest time of day. One option is to cross-train the nursing supervisor or other clinical staff to handle the duties when a case manager is not in the ED, Magee suggests.

Cesta recommends that RN case managers and social workers cover the ED 18 hours a day. She suggests staggering the shifts of the nurses and social workers, such as having the social worker come in at 8 a.m. and the nurse at 11 a.m.

One hospital Cesta worked with has three nurses and two social workers assigned to the ED. "By staggering their shifts, the emergency department is covered from 8 a.m. to 10 p.m.," she says. ■

ED Case Managers Help with Status, Level of Care, and More

Role has evolved to an essential one

With auditors from CMS and commercial payers scouring patient records for potential denials, it's essential to have case managers in the ED to work with physicians to ensure that the patient status and level of care are correct and to make sure physician documentation is detailed and complete, says **Karen Zander**, RN, MS, CMAC, FAAN, president and chief executive officer for the Center for Case Management.

But they can do so much more, she adds. ED case managers and social workers are needed to arrange for equipment and services for patients who can be discharged to home, develop plans for patients who frequent the ED, ensure that appropriate patients receive services at other levels of care or in the community, and facilitate tests and procedures to improve patient throughput, she says.

The role of case managers in the ED has evolved over time to include far more than just determining patient status, says **Patricia Hines**, PhD, RN, managing director and care management transformation practice lead with Novia Strategies, a national healthcare consulting firm.

"Case managers have become critical members of the team at all points of access to the hospital. They collaborate with the emergency department physicians on patient status, the best plan of care, and the best level of care. They work with the social workers on patients' psychosocial issues, assist with setting up community resources, and provide support for family members of patients who are seriously ill or injured," she says.

Physicians and nurses in the ED often are pressed for time and focus on the emergency at hand, take care of the patient's immediate needs, then move on to the next patient without looking at the bigger picture, says **Toni Cesta**, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts.

"CASE MANAGERS HAVE BECOME CRITICAL MEMBERS OF THE TEAM AT ALL POINTS OF ACCESS TO THE HOSPITAL."

The ED case manager can fill in the gaps by conducting an assessment of the patient, reviewing the entire patient record and looking for patterns or recurring problem. If patients can be treated at another level of care or need another service, the case manager or social worker can set it up and prevent a hospital admission, she adds.

For instance, Zander points out that elderly people often become debilitated during a hospital stay and it's in their best interest to help them avoid an admission if at all possible. "Emergency department case managers can identify alternative levels of care and facilitate a transfer, or line up services like home health or housekeeping assistance so they can avoid an acute care stay," Zander says. She adds that some hospitals have specialized EDs geared specifically to elderly patients. "Emergency personnel in these facilities receive training in geriatrics, and the case managers and social workers use targeted assessment categories such as depression," Zander says.

Patients may make frequent ED visits as they near the end of life, Cesta says. If there are case managers on hand, they can facilitate hospice referrals, which can improve the patients' quality of life and reduce hospital mortality statistics, she says.

They can facilitate a palliative care consultation for patients who frequently come in for relief of pain and other symptoms, potentially helping avoid hospitalization as well as reducing ED visits, she adds.

"Patients who visit the emergency department frequently aren't necessarily experiencing behavioral health issues or seeking drugs. They may be floundering and interpreting their issue as an emergency. These are the kind of patients who need help navigating where to go," Cesta says. Case managers or social workers can help these patients identify a primary care provider and refer them to community agencies that can help with their psychosocial needs.

ED case managers can assist with patient throughput by ensuring that patients who can be treated at a lower level of care are appropriately

admitted to that level of care and by coordinating with the bed control staff when patients are likely to need an inpatient bed.

Preventing readmissions is part of the ED case manager's role, says **Nancy Magee**, BSN, MSN, RN, senior consultant for Novia Strategies.

"Most hospitals employ a tracking system that can flag patients based on recent hospital admissions or frequent emergency department visits. Emergency department case managers should be looking at the records of these patients to determine why they are coming back and if the readmission can be avoided," she says. This could mean adding community services, helping with appointments, finding financial support for prescriptions, or evaluating family support systems, she says.

Cesta suggests that ED case managers conduct a root cause analysis to determine the reason a patient is being readmitted, develop a solution to the problem, and include it in the plan of care.

Many times, patients come back to the hospital after discharge because of pharmacy issues, Cesta point out.

"One of the biggest causes of readmission is patients who don't take their prescriptions, and in some cases never get them filled. If case managers get them filled before they leave, that increases the probability they will take them," Cesta says.

Or it could be because of polypharmacy issues, Hines adds. Patients may be taking their old medication as well as medications prescribed in the hospital, or they may be taking drugs that interact with each other. Hines recommends that case managers arrange a pharmacy consultation when recently discharged patients return to the ED.

"Part of the role is to make sure patients are connected to post-acute providers. If emergency department physicians know a patient is going to have a follow-up appointment, they may feel more comfortable discharging the patient. Case managers should make sure the patient will have support at home and that post-acute providers have what they need to care for the patient," Magee says. ■

What Makes a Good ED Case Manager?

Ability to work quickly tops the list

Successful ED case managers need to be highly skilled with a high level of clinical knowledge, the ability to work quickly, and good organizational skills, says **Patricia Hines**, PhD, RN, managing director and care management transformation practice lead with Novia Strategies, a national healthcare consulting firm.

ED case managers have to be comfortable working quickly, adds **Nancy Magee**, BSN, MSN, RN, senior consultant for Novia Strategies. "The volume of patients seen in the emergency department, the need to move patients through quickly, and government regulations all mean that case managers have to work at a more rapid pace than those on the inpatient units," she says.

Candidates should have the skills to complete a quick assessment of patients, often with less information that they would have on the unit, says **Karen Zander**, RN, MS, CMAC, FAAN, president and chief executive officer for The Center for Case Management. Former ED nurses and social workers make the best ED case managers, Zander adds.

"The case managers in the emergency department don't have a lot of time and often they have limited information. They have to be able to make an accurate determination of whether the patient should be admitted as an inpatient, placed as an observation patient, or not admitted at all. If patients can be discharged, they need to be able to quickly organize the services and other resources the patient will need in the community," Zander says.

"To be effective, emergency department case managers have to have the big picture of what is going on in the entire health system and be aware of the financial implications of the decisions they are making. They need to be knowledgeable about alternative levels of care and treatment venues and be able to link patients to resources in the community," Hines adds.

Training for the ED case managers and social workers should include a review of the requirements from CMS and commercial payers, including medical necessity criteria, payer authorization requirements, and the Two-Midnight Rule, Magee says.

"They should be able to recognize patients with a high rate of recidivism and link them with appropriate community resources that will ensure a safe transition and help them choose a more effective treatment venue than the emergency department," she adds.

Magee suggests that new ED case managers spend time with the ED charge nurses to learn the flow of the department and become familiar with what the clinical teams do and how they work. ■

Look Through Patients' Eyes to Improve the Delivery of Care

Six-step program helps identify the ideal experience

The University of Pittsburgh Medical Center has improved care delivery, increased patient satisfaction, and lowered cost of care by developing and implementing a six-step approach to understanding the healthcare experience from patients' and family members' viewpoints.

"Healthcare providers should view all care as an experience through the eyes of patients and families," says **Pamela Greenhouse**, MBA, executive director of the Patient and Family Centered Care Innovation Center at the 21-hospital healthcare system.

"In 2006, Anthony DiGioia, MD, a practicing orthopedic surgeon, developed the Patient and Family-Centered Care [PFCC] methodology to improve the experience of care and implemented it with patients undergoing hip and knee replacement surgery," Greenhouse says. When the pilot project was successful in improving clinical outcomes and decreasing costs as well as improving the patient experience, the program was expanded to other parts of the hospital.

"We proposed implementing the program in a more complex care setting and tried it in the trauma service at our flagship hospital. They have made many changes as a result of the program and continue to do so," Greenhouse says.

Today, UPMC has more than 70 cross-functional, multidisciplinary working groups at eight UPMC hospitals, outpatient sites, pre-acute, and post-acute facilities. In addition, the PFCC methodology is now being used in hundreds of care settings around the world, Greenhouse says.

The teams are using the six-step PFCC methodology to identify gaps and develop changes that will improve the patient experience and clinical outcomes while decreasing costs, Greenhouse says. The teams include clinicians and non-medical staff — anyone who touches the experiences of patients and families, including administrators, parking staff, billers, and schedulers.

None of the teams at UPMC have suggested solutions that involve adding more staff, Greenhouse reports. "The vast majority of initiatives don't cost anything other than the time staff members spend each week implementing them," she adds.

The only way to improve the experience of patients and their family members is to listen to them and find out what they are feeling, Greenhouse says. She suggests talking to patients and family members about their experiences, reviewing patient letters and surveys, and inviting patients and family members to participate in your improvement initiatives.

Shadowing patients and their family members to find out their experiences is a key to improving the experience of patients and their families, Greenhouse says.

When they shadow patients, the staff members have an opportunity to see firsthand what goes right and what goes wrong for patients and identify areas where processes can be improved, she adds.

"Shadowing gives us a picture of what is happening and identifies areas for improvement. If someone shadows one time, they will see actionable opportunities. If they shadow several times, they will see even more," she says.

Since it would be next to impossible for one person to stay

EXECUTIVE SUMMARY

By developing and implementing a method for seeing the healthcare experience from the standpoint of patients and family members, the University of Pittsburgh Medical Center has improved care delivery, lowered costs, and improved patient satisfaction.

- Cross-functional, multidisciplinary teams use a six-step patient and family-centered care methodology to identify gaps and develop changes that will improve the patient experience and clinical outcomes.
- Committee members shadow patients and family members to get firsthand knowledge about what they are going through and what goes wrong and what goes right.
- The teams proposed minor and major changes, but none involve adding more staff and few involve more expenditures.

CASE MANAGEMENT INSIDER

CASE MANAGER TO CASE MANAGER

Re-Engineering Your Case Management Department: It's Simple, It's Just Not Easy, Part 1

By Toni Cesta, Ph.D., RN, FAAN

Introduction

Acute care or hospital-based, case management really took a foothold in hospitals following the introduction of the Inpatient Prospective Payment System (IPPS) in the mid-1980s. Prior to that time, hospitals were reimbursed under a fee-for-service methodology. This meant that hospitals billed, and were paid, for services provided with few questions asked. It has been fairly well-established that this payment methodology resulted in abuse and overuse of healthcare resources. It was during the late 1960s and 1970s that healthcare costs skyrocketed with seemingly no end in sight.

It was based on these skyrocketing costs that the Centers for Medicare & Medicaid Services (CMS) introduced a significant change to the way hospitals were reimbursed under the fee-for-service system. CMS, known at that time as the Health Care Financing Administration (HCFA), determined to introduce a payment system that would control costs and manage or reduce length of stay.

IT WAS BASED ON THESE SKYROCKETING COSTS THAT CMS INTRODUCED A SIGNIFICANT CHANGE TO THE WAY HOSPITALS WERE REIMBURSED UNDER THE FEE-FOR-SERVICE SYSTEM.

Diagnosis-Related Groups

The IPPS and diagnosis-related groups (DRGs) were probably the strongest catalysts for the movement of case management from the community to the acute care setting. Under fee-for-service (FFS) plans there were no financial incentives for hospitals to reduce cost and length of stay. In the 1960s and 1970s, public policy was focused on improving access to services. Medicare, Medicaid, and other programs were designed to make services available to the poor, the disabled, and the elderly.

By the early 1980s, cost containment had become the driving issue. Healthcare policy had begun to shift from the issues of access and entitlements to quality, cost, and fiscal monitoring. The IPPS was initiated to control hospital costs by providing a price-per-case reimbursement. The onus of responsibility was shifted to the provider to manage resource utilization as a set reimbursement would be allotted. The tool designed to determine the amount of reimbursement was the DRG. It was believed that the DRG would encourage physicians, nurses, ancillary departments, and administrators to work together to provide the most efficient care and to manage the patient through the system as efficiently as possible. It was also believed that the IPPS would help standardize care and improve the efficiency of the care process. In reality, though the DRG controlled the payment rate the hospital was to receive, it did not control the cost of care. Therefore, despite these rather dramatic and strict reimbursement schemes, hospital costs continued to escalate. This resulted in the resurgence of the managed care reimbursement systems in the 1990s, especially capitation.

Acute Care Case Management Emerges

In 1985, the IPPS was advanced to allow some states to designate reimbursement rates for Medicaid and all

other third-party payers. Based on hospitals' experiences with the Medicare DRGs and the advent of the system at the state level, strong incentives appeared for the control of hospital resources. Regardless of the cost incurred for caring for a particular case type, the hospital would still be reimbursed a fixed amount of money based on the coded DRG.

It was recognized rather quickly that RNs could play a vital role in managing these dwindling healthcare dollars. The RN's role became increasingly important in terms of the following:

- coordination of tests, treatments, and procedures,
- confirmation of physician orders,
- accurate documentation,
- timely admissions,
- necessary patient and family teaching, and
- timely discharges.

In the past, much of the care process had a life of its own, running its course to completion. There were few financial incentives to control the healthcare process; in fact, there were disincentives. In an FFS environment, longer lengths of stay and greater use of product resources translated into greater revenue and financial success for the hospital. The IPPS changed all that. It became important to maximize the patient's hospital stay by coordinating the flow of patient care activities. This meant coordination of the patient's tests, treatments, and procedures so that delays could be avoided. Additional strategies included the confirmation of physician orders and/or questioning of their appropriateness when necessary. Getting the patient into and out of the hospital on time were other strategies for maximization.

The introduction of effective case management programs was slow to take hold. Costs continued to rise and employers continued to seek solutions to the high cost of purchasing healthcare insurance for their employees. This opened the door for the managed care industry to enter. By offering purchasers healthcare insurance products at lower cost, they began to shift the structure away from indemnity plans to managed care plans such as HMOs (health maintenance organizations) and PPOs (preferred provider organizations), just to name two.

ALTHOUGH CASE MANAGEMENT INITIALLY ADDRESSED THE CHANGES NECESSARY FOR ORGANIZATIONS TO SURVIVE PROSPECTIVE PAYMENT, IT WAS EVEN MORE EFFECTIVE IN ITS MANAGEMENT OF CASES UNDER A MANAGED CARE SYSTEM.

These shifts resulted in the IPPS system for government payers and the managed care system for commercial plan purchasers. These systems needed even greater emphasis on case management as a tool to manage cost and length of stay.

Although case management initially addressed the changes necessary for organizations to survive prospective payment, it was even more effective in its management of cases under a managed care system. In both reimbursement systems, patient care must be managed and controlled with a tight rein on the use of resources, the length of stay, and continuing care needs.

The majority of the models of the 1980s did little in terms of changing the role functions of the other members of the healthcare team. Whereas nursing provided the driving force for the movement toward hospital-based case management, the other disciplines were slower in recognizing the value of such a system. Additionally, serious downsizing was only just beginning in the industry. Corporate America had already begun its massive layoffs and downsizing initiatives. Thousands of people lost their jobs. Healthcare had not yet begun to feel the economic pinch as it was being felt in other businesses; the incentive for merging and downsizing departments was not yet there.

Shortly after these early models, case management began to mature as more and more hospitals began to implement case management models. One could see a direct correlation between the degree of managed care infiltration and the use of case management. In nursing case management, the nurse essentially functions as the leader of the team, similar to the team nursing approach. The difference was that the team did not consist of nurses only. Now the team was an interdisciplinary one, and each healthcare provider had a say in terms of how a patient's care would be delivered and monitored.

Healthcare Reform

Both the prospective payment system and managed care infiltration necessitated a reassessment of the industry's work, how it was organized, and how it was evaluated. Healthcare reform has now added the need for reassessment of healthcare business. The process of getting reform in healthcare was a long one, taking more than 20 years. Reform was a major issue for the presidency of Bill Clinton. The first program of reform, introduced by Hillary Clinton in 1993, was not enacted into law. During the Bush administration, several acts introduced were aimed at reducing the overall growth of healthcare costs. Other programs looked at proposals to guarantee access to coverage in the individual health insurance market and a for improving the quality and safety of the U.S. healthcare system. These programs continued to be debated through the 2008 presidential election by candidates Sen. John McCain and then-Sen. Barack Obama.

The game changer came in 2009 when the Congressional Budget Office (CBO) issued a preliminary analysis of the Affordable Care Act. The CBO estimated the 10-year cost to the federal government of the major insurance-related provisions of the bill to be approximately $1 trillion (Congressional Budget Office, June 15, 2009). It also provided for a reduction in the number of uninsured by about 16 million people. After President Obama was inaugurated, he announced his intent to work with Congress to construct a plan for healthcare reform. The Senate developed its own proposals while the House of Representatives worked on the Affordable Care Act. After debate in both the Senate and the House, and after many versions of the bill, it was finally voted into law on March 23, 2010. The amended bill was titled The Health Care and Education Reconciliation Act.

The Health Care and Education Reconciliation Act ensures that all Americans have access to quality, affordable health insurance and puts students ahead of private banks. The Congressional Budget Office has determined that together, these two bills are fully paid for and will ensure more than 94% of Americans have access to quality, affordable healthcare, will bend the healthcare cost curve, and will reduce the deficit by $143 billion over 10 years with further deficit reduction in the following decade.

NO HOSPITAL CAN AFFORD TO REMAIN STAGNANT IN AN ENVIRONMENT THAT SEEMS TO BE CHANGING AT A LIGHTNING PACE.

Why is this History Important?

The early models of acute care case management addressed the healthcare environment such as it was at that time. During the 1980s, CMS had not yet introduced payment penalties associated with quality and other outcomes of care. The movement of case management from a community-based model into the acute care setting was strictly aimed at reducing length of stay — and, therefore, the associated costs as length of stay dropped. The focus was on streamlining discharge planning as the primary way in which to reduce hospital length of stay. Very little consideration was given for cost reduction in terms of day-to-day resource consumption or improving patient throughput at that time. Cost of care and patient flow issues had not yet risen to the forefront because they were not yet linked to reimbursement penalties.

Then CMS instituted linkages between cost and quality through value-based purchasing and other cost-saving measures such as payment penalties for high readmission rates. These changes created the first links between the cost and quality of healthcare. It was at this juncture that the face of case management needed to begin to change. The early case management models no longer meet the needs of the changing healthcare landscape. It is for this main reason that hospitals and healthcare systems must look thoughtfully and carefully at the design, roles and functions, and expected outcomes of their case management departments.

Redesigning Your CM Department for the Future

No hospital can afford to remain stagnant in an environment that seems to be changing at a lightning pace. While the Medicare programs remained fairly constant for many years, CMS now routinely changes the penalty and reimbursement structure in addition to adding new expectations such as the Two-Midnight Rule and other similar rules and measures. Nevertheless, it seems that the case management department is often the last department to be

updated or enhanced to meet the new challenges imposed by the Affordable Care Act and value-based purchasing. This seems quite counterintuitive, as it is the case management department that is best positioned to meet the needs of these new expectations that are before us.

The Case Management Model

When looking at your department, you must start with the basic foundation of the department. The foundation upon which the department sits is the case management model used or planned to be used.

What is a model of care? A model is a description used to help visualize something that cannot be directly observed. Because care delivery models such as case management models cannot be seen, we use descriptors to provide a picture of the model in terms of its structure and processes. Roles are the set of key categories that case managers perform. Roles provide the context in which we work and can be applied differently in different settings. Within each role are a set of functions. Functions are the series of activities or tasks that are conducted within each role. They are the specific actions taken by a case manager in the performance of the specific role and are needed to complete each role. Functions may vary from model to model and from one care delivery setting to the next.

Clearly, the most effective models are those that provide a mechanism for managing patients across the continuum of care, thereby providing a seamless, integrated care process. In a managed care environment, this is most easily done because of the integrated services inherent in a managed care system. However, due to the many changes in healthcare reimbursement, case management is now being applied more readily in medical homes, health homes, and accountable care organizations. The notion of managing patients in a variety of care settings is more difficult in payer systems in which there are no incentives for various settings to communicate and/or share resources. With the advent of the medical home and health home concepts, as well as the accountable care organization, Medicare has provided new incentives that reach beyond commercial payers and deeply into the government payer arena. While managed care had traditionally been viewed as the system that provided the generalized structure and focus when managing the use, cost, quality, and effectiveness of healthcare services, it is no longer the only payer interested in managing cost.

> CASE MANAGEMENT IS DIFFICULT TO ENCAPSULATE BECAUSE IT DESCRIBES MANY DIFFERENT APPROACHES.

Many healthcare organizations have opted to first implement case management in the acute care setting. This accomplishes a number of things. First, it allows the organization to design, implement, and perfect its case management system in a more easily controlled environment: the hospital. Although it provides greater challenges in terms of the clinical management of patients in the acute care setting, it is still a place where team members are part of a team that is within the walls. In fact, the term "within the walls" has been used to aggregate those case management models that manage patients' care during the acute care portion of the illness. Among the many applications of the within-the-walls models are a host of types using the members of the team in various role functions. In most cases, the RN is used as the case manager. It is the placement of the RN in the organizational structure and the associated role functions that differentiate the various models.

Case management is difficult to encapsulate because it describes many different approaches, including a patient care delivery system, a professional practice model — a defined group of activities performed by healthcare providers in a particular setting — and services provided by private practitioners.

Whether introduced in the inpatient, outpatient, or any other setting across the continuum of care, case management models can be adapted to meet the goals of quality patient care in a fiscally responsible manner. Selection of the most appropriate model will depend on the needs of the organization, the available resources, and the expected goals and outcomes.

Summary

This month, we have begun our discussion of the reasons why this is a very good time for hospitals to review and re-engineer their case management models and departments, including the Affordable Care Act and value-based purchasing, among others. Next time, we will discuss the elements you need to review when re-enigneering your own case management department. ■

with a family through the entire hospital experience, break the entire episode of care into small increments and have staff members take turns shadowing.

The PFCC initiatives should go far beyond just improving amenities like parking and meals, Greenhouse says. For instance, when clinicians from the trauma service shadowed patients and caregivers, they learned how difficult it is for people to know who is in charge, who is directing the plan of care, and to whom they should address questions.

"Trauma patients may be seen by orthopedic surgeons, neurosurgeons, hospitalists, nurse care managers, and others. A lot of time, patients and family members may get different, conflicting information from different care providers. The neurosurgery team may say the patient needs a procedure, but the orthopedic surgeon says something different. It's very confusing and causes a lot of anxiety and frustration," she says.

Among the initiatives the trauma service working group recommended was dividing the trauma staff into three teams which follow patients throughout their stay. Each team includes an ED nurse, a hospitalist, and six or seven other members from a variety of disciplines.

"The same team follows the trauma patient from the emergency department into the operating room, the intensive care unit, and the inpatient unit and are with the patient throughout the entire stay. This arrangement gives patients and family members someone specific to meet with and has helped the care team as well because they know who to contact with questions," Greenhouse says.

The trauma service team also developed a real-time patient and family advisory council that invites patients who currently are in the hospital and their family members to meet with the leadership team and discuss what is going right and what isn't. "This ratchets up the pressure on the trauma team, but it gives them the opportunity to fix the problem while the patient is still in the hospital and take steps to prevent it from happening to someone else," she says.

> "THE TEAM CAME UP WITH THESE CHANGES BY LISTENING TO PATIENTS AND FAMILY MEMBERS. LOOKING AT CARE THROUGH THE EYES OF THE PATIENT AND FAMILY HELPS US IMPROVE THE PATIENT EXPERIENCE AND AT THE SAME TIME IMPROVE CLINICAL OUTCOMES AND LOWER COSTS."

Since the trauma service implemented the initiatives, length of stay and 30-day readmissions have decreased and patient satisfaction has increased.

When the bariatric department's working group found a significant number of readmissions of weight loss surgery patients, a chart review revealed that a large number of patients were being readmitted due to dehydration. The team worked with patients and family members to revamp the educational process and determine when is the best time to introduce educational materials. Patients told them it would be helpful to provide a measured liter bottle that showed exactly how much they needed to drink that day. When the changes were instituted, readmissions due to dehydration dropped to zero.

"The team came up with these changes by listening to patients and family members. Looking at care through the eyes of the patient and family helps us improve the patient experience, and at the same time improve clinical outcomes and lower costs," she says.

At the women's hospital, where the patient population ranges from new mothers to patients who have had breast cancer surgery to women at the end of life, case management department representatives were part of a team that came up with a way to alert the staff as to which patients are receiving palliative care. The solution is to post a photograph of a white rose on the doors of patients at the end of life.

"Patients' reasons for being in the hospital take in the full cycle of life, but we didn't have a way to make staff aware at the very sensitive time when patients are nearing the end of life. The rose on the door alerts dietary, maintenance, and other staff members who might not know the patients' situations," she says.

Shadowing helps the entire care team see what's happening during each step of the healthcare experience from the patient's and family's point of view and develop solutions, Greenhouse says. ■

Take These Six Steps to Improve the Patient Experience

Find out what people want and need

"There's no way for healthcare providers to improve the patient and family experience unless they find out what they [patients and families] truly want and need," says **Pamela Greenhouse**, MBA, executive director of the Patient and Family Centered Care Innovation Center at the University of Pittsburgh Medical Center.

"Our six-step process helps us drive change by looking through the eyes of the patient and family members," she says. The following are the six steps for improving the patient and family experience.

Step 1: Select the care experience you want to improve. This could have a narrow focus, such as pre-surgical testing for a particular diagnosis, or a broad focus, such as improving all trauma services from the ED through rehabilitation, Greenhouse says.

Step 2: Select a guiding council. The council should have a clinical champion from the area you are targeting, an administrative champion, and a coordinator. These should be people who are admired by their peers and others who can have an effect on helping drive the change, she says.

Step 3: Evaluate the current state of the chosen care experience by shadowing patients and family members every step of the way during the healthcare experience. "Shadowing helps the entire care team see what is happening from the patients' and family members' point of view," Greenhouse says. Compile reports from everyone who does the shadowing, and develop a chart that shows the key places and providers that patients and family members encounter.

Step 4: Expand the guiding council and create a full working group with representatives from every area that has an effect of the patient and family, starting with parking, if appropriate. Include patients and family members to get their additional input, Greenhouse advises.

Step 5: Write out the story of an ideal experience from the first-person viewpoint of the patient and family. "We ask the working group not to consider budgetary or time constraints but to aim high. We aren't looking for small, incremental improvements. We're looking for transformation, although the incremental improvements will come along, too," Greenhouse says.

Step 6: Form teams to address the gaps between what is happening currently and the ideal situation and come up with solutions. Half of the members should be from the working group and half should not have been involved so far, Greenhouse suggests. "This way, more people will be introduced to the approach and the working group will get input from more people and the culture change will begin," she adds. ■

Individual Malpractice Insurance Can Protect You in Case of Lawsuits

The benefits of coverage outweigh the costs

You may not think of yourself as having a lot of valuable assets that you could lose if someone sued you, but in today's litigious society, case managers should consider purchasing their own malpractice insurance, advises **Elizabeth Hogue**, Esq., a Washington, DC-based attorney specializing in healthcare.

Nurses and social workers don't typically think of themselves as having a lot to lose if they are sued but they do have assets that should be protected, Hogue points out. "These assets often include wages from employment, a home, automobiles, savings, stocks and bonds, and other investments. The only way to help ensure protection of these assets is to purchase and maintain an insurance policy," she says.

Malpractice insurance is not so expensive that it's prohibitive, and the potential benefits, including peace of mind, far outweigh the costs. Many professional

organizations partner with insurance providers and offer discounts to members, she says.

When attorneys file a malpractice lawsuit, they cast a wide net and often include anyone who has interacted with the patient, Hogue says.

"Attorneys are trained to include everyone who sees the patient in any malpractice lawsuit they file. Their point of view is that they won't know who is responsible for the injuries of damages the patient received until they sort it out later during discovery. For the sake of risk management, they can't afford to overlook someone, and that means that if they were involved with the patient, case managers are going to be included in any claim against a healthcare provider," she says.

CMS' proposed changes to the Conditions of Participation for discharge planning makes case managers more vulnerable than ever and increases the likelihood that case managers may be sued for an unsuccessful discharge, she says.

"There is no doubt in my mind that case managers may be included in lawsuits if the plan of care they develop doesn't meet the patient's needs, is incomplete, or if the patient is referred to a provider that cannot provide appropriate care," she says.

Hospitals have malpractice insurance that covers staff members, but in the case of a lawsuit, case managers need an advocate of their own, Hogue says.

"There may be instances when the best interests of the hospital and the best interests of the case manager will deviate. Then, for sure, case managers need their own representation," she says.

"THERE IS NO DOUBT IN MY MIND THAT CASE MANAGERS MAY BE INCLUDED IN LAWSUITS IF THE PLAN OF CARE THEY DEVELOP DOESN'T MEET THE PATIENT'S NEEDS."

When a lawsuit is filed the hospital's insurer will assign legal counsel to defend the claim, but that attorney will clearly represent the hospital and not the individual case manager, Hogue points out.

"In fact, if legal counsel determines that the actions the case manager took are outside his or her scope of employment, the insurance company may decide that there is no coverage for the claims filed against the case manager," she adds.

In other instances, multiple claims may be filed against the hospital and the hospital staff, including case management. "These multiple claims may exceed the limits of liability of the hospital's insurance policies. In that case, the only coverage case managers will have is the coverage they purchase for themselves," she says.

If a case manager has personal malpractice insurance and someone files a claim, the insurer will assign legal counsel who owes allegiance only to the case manager, Hogue says. "You will have legal counsel who is solidly in your corner who can, if necessary, counter arguments made by your employer's insurer that your employer's policy should not cover you," she says.

Some employers, especially large institutions and organizations, may not want their employees to have their own malpractice insurance because of concerns that it may be time-consuming for everyone if multiple attorneys are involved in the case, she says.

Hogue debunks the idea that people who have malpractice insurance are more likely to be sued. She points out that patients and their families have no way of getting information about whether someone has individual malpractice insurance before they file a lawsuit, she adds.

"Even after lawsuits are filed, rules governing discovery may prohibit attorneys from getting any information about whether the defendants have malpractice insurance and, if so, the amount of coverage," she says. ■

EXECUTIVE SUMMARY

In today's litigious society, case managers should have their own malpractice insurance to protect their assets, experts say.

- Attorneys cast a wide net and often include anyone who has interacted with the patient in malpractice lawsuits.
- When CMS' new discharge planning guidelines go into effect, case managers will be vulnerable to lawsuits if discharges are unsuccessful.
- The hospital's legal counsel will not necessarily represent the case manager's best interests, which is why case managers need their own malpractice coverage.

Fresh Policies and Procedures, Transparency Fuel ED Turnaround

When Phoenix-based Banner Health purchased Payson (AZ) Regional Medical Center in the summer of 2015, there were clear signs things needed to change. One of the biggest sore spots at the 44-bed hospital was the ED, where long waits and low patient satisfaction were tempting patients to seek other care alternatives.

However, just a few months later, average wait times have been cut in half, patient satisfaction has turned in a positive direction, and volumes are up. Hospital administrators don't point to any particular change that led to the turnaround. Rather, they credit a flurry of improvements ranging from ED staffing changes, a push for transparency, and fresh policies and procedures that are motivating personnel to collectively push for a higher level of care and service.

Match staffing to volume patterns

With his background as an emergency nurse, **Mike Herring**, MSN-L, MBA, RN, CENP, the new chief nursing officer at Banner Payson Regional Medical Center, focused much of his early attention on bringing the ED patient flow process into alignment with the other 28 hospitals in the Banner Health system.

"The model we brought here is bedside triage. Bring patients back immediately and try to decrease that time from when they walk in the door to when they see a physician," he explains. "Focus on the three time periods that you can control: door to doctor time, doctor to disposition time, and disposition to actually being discharged or admitted time."

Adjust schedules

To expedite patient flow, administrators adjusted provider schedules so that they better reflected patient volume patterns at the facility.

"They had a physician on duty 24/7, and they had a physician assistant [PA] ... who would usually come in at about 2 p.m.," Herring notes. "Historically, EDs pick up at around 11 a.m. or 12 p.m. ... but in this community the ED actually picks up at around 9 a.m. or 10 a.m. just because we are a little short on primary care physicians [in this region]."

"THE MODEL WE BROUGHT HERE IS BEDSIDE TRIAGE. BRING PATIENTS BACK IMMEDIATELY AND TRY TO DECREASE THAT TIME FROM WHEN THEY WALK IN THE DOOR TO WHEN THEY SEE A PHYSICIAN."

Consequently, the schedule for the PA was adjusted to begin at 9 a.m. or 10 a.m., depending on the day of the week.

"Now, there's two providers on board before the rush hits, which allows patients to be seen more [expeditiously]," Herring says. "Of course, this decreases length of stay and allows you to stay ahead of the curve."

Hospital management also took steps to beef up staffing in the ED to a level that is more in line with what Herring refers to as a safer staffing model. In particular, the hospital added ED techs during peak hours.

"This really empowers nurses to feel that they can manage and provide that safe care, which is what every nurse wants," he says. "They were an extremely engaged group, and they still are."

Part of this empowerment stems from the implementation of a series of standing orders that enable nurses to proceed with standard steps such as starting an IV or collecting a urine specimen when patients present with certain specific complaints.

"Applying those standing orders helps decrease that length of stay, which creates more real estate in the ED," Herring says. "It starts the ball rolling."

End-of-shift huddles

One new strategy that has been a big winner with nursing staff is end-of-shift huddles.

"Usually, the physician will pull the team together and they will review what went well and where

the challenges were. It is kind of a constant performance improvement/self-evaluation [exercise]," Herring explains. "Also, the physician will take the opportunity to discuss an interesting case, just to [develop] the nursing staff from an educational standpoint."

One of the primary dividends from these huddles is improved physician/nurse communication, Herring says.

"That is imperative, and it is huge for patient care," he adds.

Bring scribes on board

Implementing so many changes can prove daunting to existing staff. However, the fact that the hospital brought in a new emergency provider group from TeamHealth, a physician staffing organization that was already familiar with the Banner model, certainly kept the transition manageable.

One technique TeamHealth brought to bear on the ED turnaround is the use of scribes, explains **Joel Betz**, MD, the new medical director of the ED.

"The reason we use them is to get the doctor out of the computer as much as possible and back to the patient," he explains. "Scribes help us with documentation. Instead of having your face in a computer, typing, when patients are talking to you, you can look at them and see them as patients, providing a little bit better connection on a human level."

A scribe is typically on staff in the ED from 9 a.m. to 9 p.m., and he or she primarily works with the physician. It isn't complete coverage, but it makes a difference in expediting patient flow, Betz says.

"As we are doing one thing, the scribe can do another, such as getting discharge paperwork done," he explains. "There has been some research that we have done showing there is a benefit in turnaround time, productivity, and that kind of thing."

Most scribes are nursing or medical school students, so they are usually well-versed in the most recent medical terms and standard practices, Betz explains.

"We have used them at some other facilities that are a little bit bigger. You've got to judge how busy the facility is and whether it is worth having them or not, but here it does seem to be a significant benefit," he says. "I know it helps with provider satisfaction because none of us went to medical school to be computer guys. We went to medical school to be involved with people. It makes us more interactive with the patient, and it does seem to help with patient satisfaction."

Post key metrics

While all these tactics have helped, Betz notes one of the most powerful change agents has been the practice of posting key time metrics regarding patient flow so that staff can see how the department is doing collectively, and how their own performances are contributing.

"That is important because you have to have buy-in from the nurses and everyone working together to get those times down," he says. "If you feel like you are part of a team and there is something you can measure, that really seems to make a difference."

Herring concurs with these sentiments, noting that there is evidence that patients who may have previously turned to other alternatives for care are now returning to the Banner Payson ED. While average daily volume to the 10-bed ED has traditionally stood at about 44, the ED often treats 50 patients in a day, he says.

"The reputation has improved. People know they can be seen in a timely fashion, and we have staff who feel they can make a difference," Herring says. "That is where you want to be." ■

CE OBJECTIVES

After reading each issue of *Hospital Case Management*, the nurse will be able to do the following:

1. identify the particular clinical, administrative or regulatory issues related to the profession of case management
2. describe how the clinical, administrative or regulatory issues particular to the profession of case management affect patients, case managers, hospitals or the healthcare industry at large
3. discuss solutions to the problems facing case managers based on independent recommendations from clinicians at individual institutions or other authorities.

COMING IN FUTURE MONTHS

- What the Recovery Auditors are up to now
- Why case managers need to know about hospital finances
- Reaching outside the hospital walls
- How bundled payment initiatives are working out

HOSPITAL
CASE MANAGEMENT

CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:

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CE QUESTIONS

1. According to Karen Zander, RN, MS, CMAC, FAAN, president and CEO for the Center for Case Management, what is one of the most important reasons for having case managers and social workers in the ED?

A. Determine if patients meet inpatient criteria and ensure they get to the right level of care.
B. Improve patient throughput.
C. Enhance patient safety.
D. Increase patient satisfaction.

2. According to Toni Cesta, RN, PhD, FAAN, partner and consultant in North Bellmore, NY-based Case Management Concepts, how many patients can an ED case manager touch during an eight-hour shift?

A. About 10
B. About 20
C. About 30
D. Depends on the patient population.

3. When the bariatric surgery department's Patient and Family Centered Care working group at the University of Pittsburgh Medical Center analyzed patients who were being readmitted, what was the reason for a significant number of readmissions?

A. Medication issues
B. Infections
C. Dehydration
E. Inability to follow discharge instructions.

4. According to Elizabeth Hogue, Esq., a Washington, DC-based attorney specializing in healthcare, CMS' proposed changes to the Conditions of Participation for discharge planning makes case managers more vulnerable than ever and increases the likelihood that case managers may be sued for an unsuccessful discharge.

A. True
B. False